Operational Policy Letter #66 (Revised)

Department of Health and Human Services

Health Care Financing Administration

Center for Health Plans and Providers

Medicare Managed Care

March 31, 1998

BBA TRANSITION ISSUES -- 1999 CONTRACT YEAR

Note:

This OPL replaces OPL98.066 dated March 26, 1998. This revision clarifies the answer to question 2.

The following definitions, questions and answers are provided in response to the needs of current 1876 risk and future M+C organizations for certain information in preparation of 1999 contract year applications and submission of associated Adjusted Community Rate (ACR) proposals. The issues addressed in this OPL will be included in HCFA's upcoming Balanced Budget Act (B.B.A.) regulation and new ACR instructions expected to be published shortly. Please refer to these documents for further guidance.

Please note: under the BBA, each M+C plan must have a separate acr. The definition of plan under the BBA is different than under section 1876. For example, plan refers to standardized benefit and charge structures, not type of plan (e.g. HMO) or contract. In addition, the BBA changed other definitions that affect development of the ACR. For example, the basic benefit package no longer includes mandatory supplementals. Additional benefits are calculated in a different manner.

Definitions: The following terms will be used throughout this document.

Additional benefits are those non-Medicare covered health benefits (as specified by the M+C organization) offered to Medicare beneficiaries at no additional premium and waiver of cost sharing amounts for Medicare covered services funded out of the adjusted excess amount calculated in the Adjusted Community Rate (ACR).

Co-payments and co-insurance may be charged for Additional benefits.

An excess amount is created when the Average Payment Rate exceeds the Adjusted Community Rate (as reduced for the actuarial value of co-insurance, co-payments and deductibles under Parts A and B of Medicare). The excess amount is then adjusted for any contributions to a Stabilization Fund. The remainder is the adjusted excess which will be used to pay for services not covered by Medicare and/or used to reduce M+C Plan charges to the Medicare enrollee otherwise allowed to be charged for Medicare covered services (the actuarial value of Medicare's deductible and coinsurance normally charged under Original Medicare).

Additional benefits may be different for each M+C Plan offered by the M+C Organization to Medicare beneficiaries.

The **Basic Benefit Package** includes all Medicare-covered benefits (except Hospice services) and Additional benefits.

A **M+C Plan** is health benefits coverage offered under a policy or contract by a M+C organization which includes a specific set of health benefits offered at a uniform premium and uniform level of co-payment(s), co-insurance, deductible(s) to all Medicare beneficiaries residing in the service area of the M+C Plan. The specific set of health benefits would include all Medicare covered benefits (except Hospice services), Additional benefits and may include Mandatory Supplemental benefits. The M+C organization may offer Optional Supplemental benefits that may be purchased at the election of the Medicare beneficiary.

Multiple M+C Plans may be offered. All M+C Plans must be offered to all Medicare enrollees at the same premium and level of co-payments, co-insurance, and deductibles approved for each M+C Plan.

M+C Plan Benefit Period - the 12-month period, unless otherwise specified, in which the M+C Plan shall be offered starting on January 1st of each calendar year.

Mandatory Supplemental Benefits (except for MSAs) - are health benefits not normally covered by Medicare and required to be purchased as part of a Medicare beneficiary's enrollment in the M+C Plan. These services are paid for directly by (or on behalf of) the Medicare enrollee, usually in the form of premiums and co-payments, co-insurance, and deductibles. These services are included as a part of the M+C Plan elected by a Medicare beneficiary. M+C organizations must ensure that Mandatory Supplemental benefits are not used to discourage enrollment by any individual or any group of Medicare beneficiaries.

Mandatory Supplemental benefits may be different for each M+C Plan offered by the M+C Organization to Medicare beneficiaries.

Optional Supplemental Benefits - are health benefits normally not covered by Medicare purchased at the election of the Medicare beneficiary and are paid for directly by (or on behalf of) the Medicare enrollee, usually in the form of premiums, co-payments, co-

insurance, and deductibles. These services may be grouped or offered individually (cafeteria style).

Optional Supplemental benefits are priced and approved through the ACR process individually for each health benefit the M+C organization chooses to offer in a M+C Plan. Once approved, the Medicare enrollee must be charged using the approved pricing structure for each Optional Supplemental benefit whether the health benefit is offered individually or as part of a grouping.

Optional Supplemental benefits may be different for each M+C Plan offered by the M+C Organization to Medicare beneficiaries.

Premiums - For purposes of this document, premiums include M+C Plan charges to the Medicare enrollees paid to the M+C organization or its designee (distinct from the Part B premium paid to Medicare) that are not on a per service basis.

Stabilization Fund - This is a non-interest bearing fund HCFA will establish at a M+C organization's request to withhold a portion of the per capita payments available to the M+C organization for payment in subsequent contract periods. The purpose of the fund is to stabilize fluctuations in the availability of additional benefits the M+C organization provides to M+C Plan Medicare enrollees.

Health Benefits - health care items and services that are intended to maintain or improve the health status of enrollees for which the MCO incurs a cost under a M+C Plan. Benefits are approved in the ACR and benefit review process.

ACR Proposal - the ACR proposal comprises both a description of the M+C Plan health benefits, premiums, co-payments, co-insurance and deductibles and the Adjusted Community Rate (ACR) pricing structure.

Service Area - the geographic area within which a beneficiary must reside in order to enroll in a M+C Plan. For coordinated care plans (HMOs, PPOs, PSOs) and network MSA plans only, the service area is the area within which a network of providers exists and that meets required access standards. The service area also defines the area where a uniform benefit package (services and costs) is offered.

Medicare Enrollee - a Medicare beneficiary who has filed an application with the plan and is included in a contract between HCFA and the M+C organization under Section 1857 of the B.B.A..

Questions and Answers

1. **What will the B.B.A. allow a M+C organization to offer to Medicare beneficiaries?**

A M+C organization must offer a M+C Plan containing a specific set of health benefits at the same premium and level of co-payments, co-insurance, and deductibles to every Medicare beneficiary throughout the service area of the M+C Plan.

M+C organizations may offer more than one M+C Plan in the service area. All M+C Plans offered to Medicare beneficiaries must contain all services normally covered by Medicare (except for Hospice services). However, these M+C Plans may include a different pricing structure, different Additional Benefits, different Mandatory Supplemental Benefits and/or different Optional Supplemental benefits.

2. **Are there any limits on what a M+C organization may charge for a specific M+C Plan?**

   Yes. A M+C organization may not charge any more than what is allowed through the ACR process. In addition, limitations previously issued in OPLs # 56 and # 57 apply. Briefly, these limitations are:

   - OPL97.056 does not allow the Medicare enrollee to be charged any cost sharing on flu shots given after January 1, 1998.
   - OPL97.057 does not allow the Medicare enrollee to be charged a deductible on screening mammography examinations provided on or after January 1, 1998.

   Please reference these OPLs for further details.

3. **Are employer group members treated differently from individual members by a M+C organization?**

   No. Employers purchasing on behalf of a group of Medicare eligible retirees must have available to them all M+C Plans offered to individuals in the service area. The employer group may offer one or more M+C Plans to their group members.

   The chosen M+C Plan(s) shall act as the base for any enhancements offered to employer group members. These services (non-Medicare-covered) would be offered only to the enrollees associated with the employer group. Such services would be considered outside the scope of the B.B.A. and do not have to be offered to other Medicare

beneficiaries in the community electing the M+C Plan (which was used as the basis for the employer group enhancement).

In addition, the employer group may agree to pay for some or all of the premiums and copayments, co-insurance and/or deductibles approved for the M+C Plan on behalf of the employer group members .

4. **Who must complete a ACR?**

   All Section 1876 risk contractors that plan to offer a M+C Plan for the 1999 contract year and all other M+C organizations that intend to offer a M+C Plan subsequent to the publication of the B.B.A. regulations (expected to be published early summer 1998). Those organizations signing a demonstration contract with HCFA should review their contract to determine if an ACR proposal must be submitted.

5. **Will the May 1, 1998 date for submission of the ACR proposal be extended for current contractors?**

   No.

6. **Are any changes allowed to the M+C Plan after the ACR proposal has been approved?**

   The current policy of allowing plans to enhance benefits will continue for 1999. HCFA may approve changes to M+C Plans through a modification of the ACR proposal before the end of the 1999 contract year only if the change(s) do not increase beneficiary liability. For example, changes may decrease M+C Plan premiums, co-payments, co-insurance, and/or deductibles or increase health benefits (add new health benefits, increase current health benefit coverage) without any additional charge(s) to the Medicare enrollee. These changes may take place during M+C Plan design and implementation periods. Changes should be submitted at least 60 days prior to the effective date of the change. HCFA will have 30 days to approve such change, so that, Medicare beneficiaries may be notified 30 days prior to approved change(s). For

example, to assure that changes are effective 1/1/99, they must be requested by 11/1/98.

Changes not approved by HCFA by July 1 may not be included in HCFA's Beneficiary Information Campaign material (for 1998 HCFA's Health Fair, and for 1999 the Comparability Chart).

Any changes in benefits or charges must be submitted as an addendum to the original submission.

7. Will M+C Plans be allowed to offer a flexible benefit option?

No. See the next question describing additional flexibility for current section 1876 contractors during a transition to the new M+C rules.

8. **What is the definition of service area where a M+C plan must be offered and when will the new definition be applied?**

The policy for M+C organizations will be defined in the June 1 regulation. Current section 1876 risk contractors who are submitting ACR proposals by May 1, 1998 will have a transition year and will not have to comply until contract year 2000.

Exception for current section 1876 risk contractors -There will be a one-year transition period for current section 1876 risk contractors to come into compliance with the B.B.A. requirement that a uniform array of services be offered at a uniform premium to all beneficiaries who reside in the service area.

In the past, risk contractors were able to segment their contracted service area for the purpose of offering different benefits or charge structures. For example, modified benefit packages were developed and offered in a subset of the contracted service area. While Medicare beneficiaries residing in the segmented service area were offered a uniform array of benefits at a uniform price, there was no uniformity across the contracted service area. To allow these risk contractors to avoid market

disruption, current contractors will be allowed to continue this practice for contract year 1999 only.

For those risk contractors that choose to continue this practice, the organization must:

- treat segmented portions of the contracted service area as though they were separate and distinct service areas that do not overlap;
- within each service area the M+C organization must offer at least one M+C Plan (uniform array of services at a uniform price) to all Medicare beneficiaries residing in the service area;
- M+C organizations will be allowed to offer multiple M+C Plans as long as each M+C Plan (uniform array of services at a uniform price) is available to all Medicare beneficiaries residing in the service area; and,
- all B.B.A. rules for each M+C Plan will apply:
    - the organization must make all health benefits offered through the M+C Plan available and accessible to each individual electing the M+C Plan with reasonable promptness and in a manner which ensures continuity in the provision of health benefits
    - a separate ACR proposal must be submitted for each M+C Plan

  For contract year 1999, a current section 1876 contractor may submit a different benefit package and/or different premium: (1) within the same service area (2) within the same contract number (3) within the same type of plan (e.g. HMO)and(4) within the same organization **as long as the M+C plan is offered uniformly to all beneficiaries who reside in the specified area and the proposal does not result in discrimination or lack of access or continuity of care.**

9. **May current risk contractors enter multiple contracts for purposes of rating or benefits?**

   Under the B.B.A., the service area determination will be applied at the level of the M+C Plan and not at the contract level.

10. What changes are being made to the ACR proposal format?

   For those current risk contractors submitting an ACR proposal by May 1, 1998 for calendar year 1999, the old ACR and BIF forms (the forms used in previous submissions) will be used.

   After publication of the regulations implementing the B.B.A., all organizations will use modified forms. Instructions on the new forms will be issued separately.

11. **What are the rules for notifying Medicare enrollees on M+C Plan health benefit and M+C Plan charge changes?**

   M+C Plans shall use the same rules that HMOs have used under Section 1876 in the past; such as, 30 day notification of any change in the M+C Plan, prior approval by HCFA

12. How long can a M+C contract period be? Will HCFA award contracts for longer than a 12-month period? How are ACR proposals completed for these types of contracts?

   The M+C contract period and ACR proposal are for 12 calendar months starting January through December of any calendar year.

   An exception to this rule will apply to organizations signing a M+C contract after the publication of the regulations implementing the B.B.A. and before December 31, 1998. These organizations will be allowed to sign a M+C contract and submit an ACR proposal that covers a period longer than 12 months. The contract period would include all of calendar year 1999 plus any months in 1998 that are included in the M+C contract signed. For specific instructions on completing the ACR form and benefit description form, the organization should

contact the appropriate personnel in Central Office (HCFA) responsible for the area.

13. **Will service area expansions(SAE) be allowed during a contract year?**

    Service area expansions may be submitted and approved on a continuous basis during a contract year. However, service area expansions approved during the contract year shall not be effective until January 1. For example, current contractors who have pending SAEs as of June 1, 1998 will not be able to *enroll* in the expanded areas until January 1, 1999.

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